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**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**CHRISTOPHER GLENNEN COONEY, M.D.**<br>**2186 Geary Blvd. Ste. 320**<br>**San Francisco, CA 94115-3457**<br><br>**Physician's and Surgeon's Certificate No. G 76882,**<br><br>Respondent. | Case No. 800-2019-059229<br><br>**A C C U S A T I O N** |

## PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On June 21, 1993, the Medical Board issued Physician's and Surgeon's Certificate Number G 76882 to Christopher Glennen Cooney, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2023, unless renewed.

## JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2228.1 of the Code states:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a

patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

6. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

7. Section 2234 of the Code states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a

separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

8. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

9. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

**COST RECOVERY**

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

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**DEFINITIONS**

11. Alprazolam (trade name Xanax) is a psychotropic triazolo analogue of the 1,4 benzodiazepine class of central nervous system-active compounds. Xanax is used for the management of anxiety disorders or for the short-term relief of the symptoms of anxiety. It is a dangerous drug as defined in section 4022 of the Code and a schedule IV controlled substance and narcotic as defined by section 11057, subdivision (d), of the Health and Safety Code. Xanax has a central nervous system (CNS) depressant effect and patients should be cautioned about the simultaneous ingestion of alcohol and other CNS depressant drugs during treatment with Xanax. Addiction-prone individuals (such as drug addicts or alcoholics) should be under careful surveillance when receiving alprazolam because of the predisposition of such patients to

habituation and dependence. The usual starting dose of Xanax is 0.25 to 0.5 mg. three times per day.

12. Benzodiazepines belong to the CNS group of medicines, which slow down the nervous system. Some benzodiazepines are used to relieve anxiety. However, benzodiazepines should not be used to relieve nervousness or tension caused by the stress of everyday life. Some benzodiazepines are used to treat insomnia (trouble in sleeping). However, if used regularly (for example, every day) for insomnia, they usually are not effective for more than a few weeks. Some commonly used brand names are: Ativan (lorazepam), Dalmane (flurazepam), Diastat or Valium (diazepam), Doral (quazepam), Halcion (triazolam), Klonopin (clonazepam), Librium (chlordiazepoxide), Paxipam (halazepam), ProSom (estazolam), Restoril (temazepam), Serax (oxazepam), Tranxene-SD (clorazepate), Xanax (alprazolam).

13. Buprenorphine hydrochloride (trade name Buprenex), is an injectable opioid analgesic, with 0.3 mg of Buprenex being approximately equi-analgesic to 10 mg of morphine sulfate. Buprenex is indicated for the relief of moderate to severe pain. It is a dangerous drug as defined in section 4022 of the Code, and a schedule V controlled substance and narcotic as defined by section 11058 of the Health and Safety Code. Because of the narcotic antagonist activity of Buprenex, use in the physically dependent individual may result in withdrawal effects. Buprenex is a partial agonist of the morphine type: i.e., it has certain opioid properties which may lead to psychic dependence of the morphine type due to an opiate-like euphoric component of the drug.

14. Clonazepam (trade name Klonopin) is an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in section 4022 of the Code and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazapines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have

been noted upon abrupt discontinuance. The initial dosage for adults should not exceed 1.5 mg per day divided in three doses.

15. Hydrocodone w/APAP (hydrocodone with acetaminophen) tablets are produced by several drug manufacturers under trade names such as Vicodin, Norco or Lortab. Hydrocodone bitartrate is a semisynthetic narcotic analgesic. It is a dangerous drug as defined in section 4022 of the Code, and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (e) of the Health and Safety Code. Repeated administration of hydrocodone over a course of several weeks may result in psychic and physical dependence. The usual adult dosage is one tablet every four to six hours as needed for pain. The total 24-hour dose should not exceed 6 tablets.

16. Lorazepam (trade name Ativan) is used for anxiety and sedation in the management of anxiety disorder for short-term relief from the symptoms of anxiety or anxiety associated with depressive symptoms. It is a dangerous drug as defined in section 4022 of the Code, and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Lorazepam is not recommended for use in patients with primary depressive disorders. The initial dose of this drug for elderly patients should not exceed 2 mg per day. Sudden withdrawal from lorazepam can produce withdrawal symptoms including seizures. The usual dosage range is 2 to 6 mg per day given in divided doses, the largest dose being taken before bedtime, but the daily dosage may vary from 1 to 10 mg per day.

17. Methadone hydrochloride (trade names Methadose and Dolophine) is a synthetic narcotic analgesic with multiple actions quantitatively similar to those of morphine. It is a dangerous drug as defined in section 4022 of the Code and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (c) of the Health and Safety Code. Methadone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of methadone, and it should be prescribed and administered with the same degree of caution appropriate to the use of morphine. Methadone should be used with caution and in

reduced dosage in patients who are concurrently receiving other narcotic analgesics. The usual adult dosage is 2.5 mg to 10 mg every three to four hours as necessary for severe acute pain.

18. Naloxone is a medication approved by the Food and Drug Administration (FDA) designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids such as heroin, morphine, and oxycodone. Administered when a patient is showing signs of opioid overdose, naloxone is a temporary treatment and its effects do not last long. Therefore, it is critical to obtain medical intervention as soon as possible after administering/receiving naloxone. The medication can be given by intranasal spray (into the nose), intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection. A practitioner should assess the need to prescribe naloxone for patients who are receiving medication-assisted treatment (MAT) or otherwise considered a risk for opioid overdose.

19. Oxycodone hydrochloride (trade names OxyContin® and Xtampza) is a dangerous drug as defined in Code section 4022 and a schedule II controlled substance as defined by section 11055, subdivision (b)(1)(N), of the Health and Safety Code. Oxycodone is a white, odorless crystalline powder derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other CNS depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol.

20. Oxycontin is a trade name for oxycodone hydrochloride controlled-release tablets. Oxycodone is a white odorless crystalline powder derived from the opium alkaloid, thebaine. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of oxycodone include anxiolysis, euphoria, and feelings of relaxation. It is a dangerous drug as defined in section 4022 of the Code and a schedule II controlled substance and narcotic as

defined by section 11055, subdivision (b)(1) of the Health and Safety Code. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycontin should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers, and alcohol. Interactive effects resulting in a respiratory depression, hypotension, profound sedation or coma may result if these drugs are taken in combination with the usual doses of Oxycontin. Oxycontin is a mu-antagonist opioid with an abuse liability similar to morphine. Delayed absorption, as provided by Oxycontin tablets, is believed to reduce the abuse liability of a drug.

21. Tramadol hydrochloride (trade name Ultram), is a centrally acting synthetic analgesic compound. It is a dangerous drug as defined by Code section 4022, and a schedule II controlled substance as defined by section 11057 of the Health and Safety Code. Ultram is indicated for the management of moderate to moderately severe pain.

## FIRST CAUSE FOR DISCIPLINE

**(Unprofessional Conduct; and/or Repeated Negligent Acts; and/or Prescribing without an Appropriate Medical Examination/Medical Indication; and/or Inadequate Medical Record Keeping in the Care Provided to Patient 1)**[1]

22. Respondent Christopher Glennen Cooney, M.D. is subject to disciplinary action under sections 2234, 2234, subdivision (c); and/or 2242, and/or 2266 of the Code, regarding his treatment of Patient 1, born in 1944. The circumstances are as follows:

23. Respondent treated Patient 1 from 2011 through January 2020. Respondent's record indicates this 73-year-old woman had hypertension, obesity, chronic hepatitis C, pulmonary sarcoidosis, and chronic low back and knee pains due to osteoarthritis. Prior to seeing Respondent, Patient 1 was receiving opiate medications from an orthopedic surgeon for the chronic low back and knee pain.

[1] Names are redacted to protect privacy interests. Respondent knows the names of the patients and can confirm identities through discovery.

24. When Respondent took over Patient 1's care, Respondent continued her chronic opiate therapy of oxycontin SR (sustained release) and oxycodone IR (instant release), at a daily total of 560 mg oxycodone. This prescribing correlated to a morphine equivalent daily dose (MEDD)[2] of 840. Respondent had Patient 1 sign a pain management agreement in January 2014.

25. A review of the Controlled Substance Utilization Review and Evaluation System (CURES)[3] report shows that Respondent was providing Patient 1 monthly prescriptions of oxycontin and oxycodone at an MEDD of 840 mg from October 2014 (when the CURES report starts) through January 2017.

26. Respondent's chart, beginning in 2015, for Patient 1 shows the patient was seen in the clinic on a monthly basis for opiate medication refills. Most of the visits had no relevant musculoskeletal examinations and no functional assessments of opiate therapy. Patient 1 was offered physical therapy in late 2015 but declined it.

27. Patient 1 continued seeing Respondent on a monthly basis during 2016 for narcotic refills. Again, there were not many relevant physical examinations documented. During most of the visits neither the oxycodone and oxycontin prescriptions, nor their dosages, were documented. The entry was simply "pain medications given." The only documented functional assessments of the long term opiate therapy were done in June and December of 2016.

28. In January 2017, Patient 1's insurance company denied the oxycontin (sustained release) coverage. The records show Respondent appealed on behalf of Patient 1 but the medication was still denied. Due to the coverage denial, beginning January of 2017, Patient 1's monthly opiate dosage automatically dropped down to oxycodone IR 240 mg daily (MEDD of 360 mg).

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[2] MEDD stands for morphine equivalent daily dose. This is used to convert the many different opioids into one standard value based on morphine and its potency. Oxycodone, for example, is 1.5 times as potent as morphine so 100 mg of oxycodone is equivalent to 150 MEDD.

[3] CURES (Controlled Substance Utilization Review and Evaluation System) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies and law enforcement.

29. When insurance denied the oxycontin coverage, Patient 1's daily MEDD was quickly reduced by more than fifty percent. Respondent's chart for Patient 1 did not note any worsening functional status or increased pain levels. Patient 1 remained on a MEDD 360 mg through most of 2018, but these prescriptions were not documented in the chart notes. Only the August and December 2018 visits documented Patient 1's functional status in detail.

30. Respondent failed to assess, recognize, and/or document Patient 1's opioid tolerance and possible opioid induced hyperalgesia syndrome (a paradoxical increased pain response to increasing narcotic dosage). Hyperalgesia syndrome is dealt with by reducing narcotic dosage or by opioid rotations to other narcotics at reduced dosage because pain receptors are more sensitive to different opiates at a lower equivalent dosage. Patient 1's abrupt reduction of opiate dosage in January 2017, without any concomitant increase in pain, confirmed she had likely developed opioid induced hyperalgesia syndrome.

31. In January of 2019, Respondent reduced Patient 1's dosage of oxycodone to 180 mg (MEDD of 270 mg) for reasons not clearly documented in the records provided. Patient 1 was maintained on this dosage until September 2021, the final date of the provided CURES report.

32. During the years of care, Respondent did not perform and/or document an opiate risk assessment on Patient 1. There was no discussion/documentation in Patient 1's chart of any informed consent regarding the risks and benefits of long term opiate therapy. More specifically, Respondent's chart notes for Patient 1 did not document any risk/benefit analysis weighing why this elderly patient required long term opiate therapy (of MEDDs from 840 through 360 mg) despite known risks in elderly populations due to risk of memory impairment, mechanical falls/fractures, vehicular accidents, osteoporosis, and slowed reaction time. Respondent's chart contained no record of Patient 1 being prescribed naloxone to minimize the risk of overdose, especially given the comorbidities of Patient 1 who also suffered from pulmonary sarcoidosis with chronic dyspnea. Respondent never ordered/performed and/or documented any urine toxicology tests for Patient 1.

33. Patient 1's chart did not contain any documentation regarding the consideration or prescribing of safer non-addictive pain medications like NSAIDS (non-steroidal anti-inflamatory drugs), SSRI (selective serotonin reuptake inhibitors) like duloxetine, non-addictive muscle relaxants, gabapentin or pregabalin, and topical therapies. Patient 1's chart did not contain referrals/consultation with pain management for treatments such as epidural steroid injections or nerve ablations therapy of the spine. There was no referral or documentation for orthopedic consultation for evaluation of the knees or joint injections. There was no referral or documentation for chiropractic manipulation or acupuncture. There was no referral or documentation for cognitive behavioral therapy for coping with chronic pain.

34. Respondent's overall care and treatment of Patient 1 constitutes unprofessional conduct through repeated negligent acts and/or prescribing without an appropriate medical examination or medical indication and/or failure to maintain adequate and accurate medical records for reasons including, but not limited to, the following:

a. Respondent failed to provide non-opiate medications for pain management, and/or document providing non-opiate medications;

b. Respondent failed to refer Patient 1 to a pain management specialist or an orthopedic specialist for procedural interventions, and/or document such referrals;

c. Respondent failed to recommend chiropractic manipulations or acupuncture therapy, and/or document such recommendations;

d. Respondent failed to consider/refer Patient 1 to cognitive behavioral therapy to help the patient better cope with chronic pain symptoms, and/or failed to document such referrals;

e. Respondent failed to perform proper opioid risk stratification, and/or document any risk stratification;

f. Respondent did not institute a multi-disciplinary management approach to reduce Patient 1's narcotic dependency, and/or failed to document any multi-disciplinary management;

g. Respondent failed to conduct or order regular urine drug testing to assess for diversion or improper use, and/or failed to document any urine drug testing;

h. Respondent prescribed long term oxycodone therapy at an excessive dosage to an elderly patient without sufficient medical indication or examination, and/or failed to document the medical indication/examination;

i. Respondent failed to prescribe naloxone therapy to Patient 1 who was on a high narcotic dosage and had underlying pulmonary disorders, and/or failed to document the prescription;

j. Respondent failed to recognize opiate tolerance and opioid hyperalgesia syndrome in Patient 1 and/or failed to document such findings/concerns;

k. Respondent did not have an informed consent discussion for the high oxycodone dosage, and/or failed to document such a discussion;

l. Respond failed to clearly document the narcotics prescribed;

m. Respondent's documentation of musculoskeletal examination and functional assessment was insufficient;

n. Respondent failed to discuss recommended lifestyle changes for pain improvement and opiates risks with Patient 1, and/or failed to document such discussions.

## SECOND CAUSE FOR DISCIPLINE

**(Unprofessional Conduct; and/or Gross Negligence and/or Repeated Negligent Acts; and/or Prescribing without an Appropriate Medical Examination/Medical Indication; and/or Inadequate Medical Record Keeping in the Care Provided to Patient 2)**

35. Respondent Christopher Glennen Cooney, M.D. is subject to disciplinary action under sections 2234, 2234 subdivision (b), 2234 subdivision (c); and/or 2242, and/or 2266 of the Code, regarding his treatment of Patient 2, born in 1980. The circumstances are as follows:

36. Respondent treated Patient 2 from November 2012 through 2016. The records provided showed Patient 2 was a 35-year-old man with a history of chronic headaches, fibromyalgia, chronic arm pains due to prior fractures, bipolar illness, chronic insomnia, and drug addiction. Patient 2 was already taking hydrocodone and benzodiazepines when Respondent began treating him.

37. In 2013, Respondent noted that the hydrocodone was not helping Patient 2's headaches, so Respondent switched Patient 2 to oxycodone. Respondent also began prescribing pregabaline and triptans for additional relief of pains and headaches.

38. In 2014, Respondent prescribed Patient 2 at least thirteen prescriptions of oxycodone (60-120 tablets per prescription), six prescriptions of alprazolam, two prescriptions of tramadol, two prescriptions of clonazepam, and two prescriptions of methadone. The clinical chart showed minimal details of physical examinations and functional assessments of the opiate therapy.

39. Patient 2 was incarcerated for 30-60 days in late 2014, with a concomitant gap in narcotic refills in November and December of 2014.

40. Patient 2 was next seen by Respondent in January 2015. Respondent immediately resumed Patient 2 on 90 mg daily oxycodone, 20 mg daily of methadone, and 4 mg daily of alprazolam, a total 215 mg MEDD. The risk of accidental respiratory failure and overdose was increased by the fact that Patient 2, having been narcotic free while in custody, had likely lost his high opiate tolerance.

41. In March of 2015, Respondent prescribed oxycodone at 90 mg daily (total of 135 mg MEDD) without sufficient clinical assessment.

42. Patient 2 was in a drug rehabilitation program for the next few months, so he did not see Respondent from April 2015 through August 2015. Respondent did not prescribe any narcotics at the September 2015 visit.

43. The next documented visit, in April of 2016, Respondent suspected that Patient 2 had relapsed back into drug abuse. During the board interview, Respondent reported that Patient 2 appeared to be in withdrawal and was threatening to use street drugs to cope with the withdrawal. Respondent prescribed Patient 2 120 tablets of 30 mg oxycodone and 60 tablets of 1 mg lorazepam. Respondent did not chart any referral to an outpatient chemical dependency program or hospitals for inpatient drug detoxification. Nor did Respondent prescribe buprenorphine or methadone for the withdrawal symptoms.

44. Patient 2's final visit with Respondent was in May of 2016, when Respondent again prescribed 60 tablets of 30 mg oxycodone and 60 tablets of 2 mg alprazolam.

45. Patient 2's chart did not contain any documentation regarding the consideration or prescribing of safer non-opiate pain medications like various NSAIDS, non-addictive muscle relaxants, higher dosages of gabapentin, and topical therapies. Patient 2's chart did not contain referrals/consultation with pain management experts for treatments such as muscle trigger point injections or a neurology expert referral for botulinum injections to help with headaches. There was no consultation/documentation by a rheumatology expert to manage fibromyalgia pain syndrome. There was no documentation of any close monitoring with mental health staff for cognitive behavioral therapy. There was no documented consideration of acupuncture or chiropractic manipulation to reduce the need for opiate medications.

46. Respondent did not perform and/or document any opiate risk assessment during his care of Patient 2. Respondent noted in the August 2014 clinic note that Patient 2 should enter a drug rehabilitation program but did not refer and/or document any such referral. Respondent did not order urine toxicology testing and/or document such tests during 2015-2016, nor were CURES queries for Patient 2 done regularly during this time period.

47. Respondent never performed a comprehensive and thorough evaluation of Patient 2's anxiety disorder, for which he prescribed alprazolam or lorazepam intermittently from 2012 through 2016. There was no screening anxiety questionnaire in the chart. There was no detailed history of the triggering and relieving factors of anxiety. There was no assessment of the functional limitations posed by the anxiety. There was no laboratory evaluation to assess for non-psychiatric causes of anxiety. Opioid dependency and withdrawal is often linked to anxiety due to opioid withdrawal – treatment for such anxiety should be opioid tapering with trial of non-benzodiazepine anxiolytic, that was not done.

48. There was no discussion or documentation in Patient 2's chart of any informed consent regarding the risks and benefits of long term opiate therapy. Respondent did not document an appropriate indication for prescribing benzodiazepine medications to Patient 2.

Nor was there sufficient documented medical indication for long term opiate therapy in this opiate addicted patient. The combination of benzodiazepines and opiates unnecessarily exposed Patient 2 to increased risks of accidental overdose. Respondent never prescribed and/or documented a prescription of naloxone to minimize the risk of accidental overdose.

49. Respondent did not document any relevant musculoskeletal examination in any of the visits during which he prescribed narcotics to Patient 2. Respondent did not document any detailed and appropriate functional assessments of opiate therapy such as analgesic effects, adverse side effects, daily activities, aberrancy, and personal affect. The opiates that were prescribed were documented but the chart did not document the accurate dosages being prescribed.

50. Respondent's overall care and treatment of Patient 2 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or prescribing without an appropriate medical examination or medical indication and/or failure to maintain adequate and accurate medical records for reasons including, but not limited to, the following:

a. Respondent failed to prescribe safer non-opiate pain medications, and/or failed to document such prescriptions;

b. Respondent failed to consider specialty consultations for better management of Patient 2's chronic headaches and fibromyalgia syndrome and/or failed to document such referrals;

c. Respondent failed to recommend acupuncture therapy or chiropractic manipulation and/or failed to document such recommendations;

d. Respondent failed to properly risk stratify Patient 2 during 2015-2016, and/or failed to document such risk stratification;

e. Respondent failed to offer a multi-disciplinary management approach to this patient with a substance abuse disorder, and/or failed to document such a multi-disciplinary approach;

f. Respondent resumed Patient 2's opiate regimen in January 2015, at an excessively high dosage, without sufficient medical indication or examination;

g. Respondent prescribed narcotics to this opioid addicted patient in April and May of 2016 without actively trying to help with detoxification treatment, and/or failed to document such a detoxification attempt;

h. Respondent failed to conduct urine toxicology testing during 2015 and 2016, and/or failed to document such testing;

i. Respondent failed to conduct CURES queries in 2016, and/or failed to document such queries;

j. Respondent failed to prescribe naloxone antidote to this high risk patient, and/or failed to document a naloxone prescription;

k. Respondent failed to perform a thorough evaluation of Patient 2's anxiety disorder, and/or failed to document the evaluation;

l. Respondent failed to trial a safer non-addictive anxiolytic medication in 2015-2016, and/or failed to document such trials;

m. Respondent prescribed benzodiazepines concurrently with opiate medications without sufficient medication examination or indication, and/or failed to document such examination/indication;

n. Respondent failed to provide informed consent for the long-term use of opiates and benzodiazepines, and/or failed to document the informed consent.

## THIRD CAUSE FOR DISCIPLINE

**(Unprofessional Conduct; and/or Gross Negligence and/or Repeated Negligent Acts; and/or Prescribing without an Appropriate Medical Examination/Medical Indication; and/or Inadequate Medical Record Keeping in the Care Provided to Patient 3)**

51. Respondent Christopher Glennen Cooney, M.D. is subject to disciplinary action under sections 2234, 2234 subdivision (b), 2234 subdivision (c); and/or 2242, and/or 2266 of the Code, regarding his treatment of Patient 3, born in 1973. The circumstances are as follows:

52. Respondent has been prescribing controlled substances to Patient 3 as early as October 2014, based on CURES. In his interview, Respondent reported that Patient 3 has been his patient since 2001. The requested medical chart records began in 2019 and showed Patient 3 was a 45-year-old woman with chronic low back and knee pain due to osteoarthritis and chronic migraine headaches. Patient 3 also suffered from generalized anxiety disorder and a mood disorder, unspecified.

53. Respondent shared, during the Board interview, that Patient 3 developed a substance abuse disorder with opioids around 2008 and was transitioned to methadone.

54. Patient 3's CURES report shows that by July 2015 Respondent was prescribing Patient 3 140 mg of methadone daily (MEDD 1680 mg) and 3 mg of lorazepam daily. Respondent maintained Patient 3 on this prescription regimen until January 2020. There were no urine toxicology tests administered and/or documented during this period of time. There was no record of any electrocardiogram (EKG) monitoring for heart complications which can be caused by methadone.

55. There were no pain evaluations during 2015-2020, which might have uncovered additional non-opiate measures for treating chronic pain syndrome. Over the years, there were no records of any MRI or x-ray imaging. There were no records of specialty consultations or ancillary therapies like physical or cognitive behavioral therapy. There were no referrals, or documentation of referrals, for spine microsurgery and nerve ablation therapies. No neurology consultation or CT scans were ordered or documented for chronic headaches. There were no trials, or documentation of trials, for gabapentin, pregabalin, newer generations SSRIs like duloxetine, tricyclic medications, non-addictive muscle relaxants, and topical therapies to help Patient 3 reduce her methadone needs. There were also no records of referrals to acupuncture, chiropractic adjustments, or cognitive behavioral therapy.

56. There was no multi-disciplinary management approach coordinated, and or documented, with Patient 3's primary care physicians at Kaiser Medical Group to optimize her pain management.

57. Respondent prescribed lorazepam monthly from 2014 through 2021 for generalized anxiety management. There was no clear medical indication for the concurrent prescribing of methadone and benzodiazepines.

58. There was no comprehensive and thorough evaluation of an anxiety disorder, or documentation of such an evaluation. There was no screening anxiety questionnaire, no detailed history of triggering and relieving factors of anxiety, no assessment of the functional limitations posed by anxiety, no laboratory evaluation to assess for non-psychiatric causes of anxiety. A major contributing factor of anxiety in Patient 3 was opioid dependency and withdrawal syndrome. There was no documented collaboration with Patient 3's mental health staff at Kaiser to minimize Patient 3's benzodiazepine dependency.

59. In January of 2020, Respondent began tapering down Patient 3's methadone, reaching 90 mg daily by September 2021. The lorazepam remained at 3 mg daily. There was no urine toxicology testing during 2020. Naloxone was finally prescribed in April of 2020 to minimize accidental overdose risks.

60. There was no documentation of any informed consent discussion with Patient 3 regarding the risks and benefits of high dose methadone and benzodiazepine therapy. The clinic notes that were provided did not contain any detailed musculoskeletal examination, and/or functional assessments of benefits of methadone therapy.

61. Respondent's overall care and treatment of Patient 3 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or prescribing without an appropriate medical examination or medical indication and/or failure to maintain adequate and accurate medical records for reasons including, but not limited, to the following:

a. Respondent failed to properly evaluate Patient 3's chronic pains, and consider additional non-opiate measures for treating Patient 3's chronic pain syndrome, and/or failed to document such considerations;

b. Respondent failed to trial other non-opiate medications with Patient 3, and/or failed to document such trials;

c. Respondent failed to consider cognitive behavioral therapy with Patient 3 to manage the chronic pain, and/or failed to document such referrals;

d. Respondent failed to manage Patient 3's chronic pains utilizing a multi-disciplinary approach, and/or failed to document any multi-disciplinary approach;

e. Respondent failed to conduct/order any urine toxicology testing from 2015 through 2020, and/or failed to document such urine toxicology testing;

f. Respondent's choice of methadone for acute and long term pain management at an extremely high dosage was without sufficient medical indication or examination, and/or failed to document such examinations and indications;

g. Respondent's choice of methadone to treat Patient 3's opioid abuse disorder was done without sufficient medical indication or examination and/or failed to document such examinations and indications;

h. Respondent failed to recognize Patient 3's opiate tolerance to methadone, and/or failed to begin tapering down the dosage earlier than 2020;

i. Respondent failed to refer Patient 3 to an addiction medicine expert for safe tapering, and/or failed to document such a referral;

j. Respondent failed to conduct, and/or failed to document, any EKG testing for arrhythmia, or other side effects of methadone therapy, and/or failed to document such testing;

k. Respondent failed to perform a comprehensive anxiety evaluation for Patient 3 during the benzodiazepine treatment from 2015 through 2020, and/or failed to document such an evaluation;

l. Respondent failed to collaborate and coordinate with mental health specialists managing Patient 3's anxiety, and/or failed to document any collaboration/coordination;

m. Respondent failed to try additional non-SSRI medications to manage Patient 3's anxiety, and/or failed to document such trials;

n. Respondent prescribed benzodiazepines concurrently with opiate medications without sufficient medical indication or examination and/or failed to document such examinations and indications;

o. Respondent failed to provide informed consent for the long-term use of opiates and benzodiazepines, and/or failed to maintain a record of informed consent.

## FOURTH CAUSE FOR DISCIPLINE

**(Unprofessional Conduct; and/or Gross Negligence and/or Repeated Negligent Acts; and/or Prescribing without an Appropriate Medical Examination/Medical Indication; and/or Inadequate Medical Record Keeping in the Care Provided to Patient 4)**

62. Respondent Christopher Glennen Cooney, M.D. is subject to disciplinary action under sections 2234, 2234 subdivision (b), 2234 subdivision (c); and/or 2242, and/or 2266 of the Code, regarding his treatment of Patient 4, born in 1986. The circumstances are as follows:

63. Patient 4 established medical care with Respondent in 2014 and kept seeing him through 2021, according to the medical records provided and Patient 4's CURES report. Patient 4 was a 30-year-old woman with an extensive history of IV heroin abuse, leading to chronic leg neuropathy and vascular injury with chronic pains due to the frequent drug injections. She also had chronic low back pains, asthma, generalized anxiety, and mood disorder.

64. Patient 4 was enrolled in a methadone maintenance program in San Francisco before Respondent took over the responsibility of providing the methadone maintenance therapy and chronic pain management. Respondent took over prescribing Patient 4's regular methadone in February 2015, kept the dosage at 100 mgs daily (MEDD of 1200 mg), and continued her on the same prescription for the next six years. Respondent used methadone to manage the opioid substance abuse disorder, without the training in addiction medicine, and without certification to prescribe methadone therapy for opioid addiction. Despite Patient 4's opioid tolerance, there was no opioid rotation or tapering down the high doses of methadone until sometime after September 2021.

65. Patient 4's medical chart showed one x-ray done of her low back in 2014. There were no MRI or CT scans done and/or documented. There were no pain management or

orthopedic consultations recommended and/or documented as being recommended. There was no referral to addiction specialty for monitoring and/or any documentation of such referrals. There were no trials of other non-addictive medication to reduce the methadone dependency. There were no referrals for cognitive behavioral therapy to help with the diagnosed mood disorder. Overall, there was no recommendation or documentation of a multi-disciplinary management approach to managing Patient 4's needs. There was no EKG testing done to check for heart arrhythmias since methadone is known to result in prolonged QT intervals placing patients at risk of fatal cardiac arrhythmias.

66. Patient 4 signed a pain management agreement in 2015. Only two urine drug toxicology tests were conducted and/or documented for Patient 4, in August and October of 2020. Those two tests showed the presence of methamphetamines and marijuana. There is no record of Respondent addressing this violation of the pain management agreement with Patient 4.

67. Clinic notes from 2015 through 2020 were brief with no vital signs. Most of the notes lacked documentation of relevant detailed musculoskeletal examination or detailed functional assessments. The dosage of methadone prescribed was often not documented clearly. Many clinic notes only contained three to four lines of handwritten notes. There was no documentation of opioid risk stratification. There was no documentation of informed consent discussion regarding the risks and benefits of high dose methadone therapy.

68. Respondent's overall care and treatment of Patient 4 constitutes unprofessional conduct through gross negligence and/or repeated negligent acts and/or prescribing without an appropriate medical examination or medical indication and/or failure to maintain adequate and accurate medical records for reasons including, but not limited to, the following:

a. Respondent failed to properly evaluate Patient 4's chronic leg and back pains, and/or failed to document such an evaluation;

b. Respondent failed to prescribe safer and/or non-addictive pharmacotherapy for pain relief, and/or failed to document such prescriptions;

c. Respondent failed to refer the Patient 4 to a pain management consultation or orthopedic consultation until 2021, and/or failed to document such referrals;

d. Respondent failed to refer the Patient 4 to cognitive behavioral therapy by mental health staff, and/or failed to document such referrals;

e. Respondent failed to perform opioid risk stratification on Patient 4, and/or failed to document any opioid risk stratification;

f. Respondent failed to recommend/implement a multi-disciplinary management approach to manage Patient 4's chronic pain, and/or failed to document such an approach;

g. Respondent failed to routinely conduct urine drug testing for diversion and or drug abuse, and/or failed to document urine drug testing;

h. Respondent failed to address Patient 4's methamphetamine addiction, and/or failed to document addressing the issue;

i. Respondent failed to taper methadone, and/or failed to document the medical indication or examination warranting the unchanging methadone prescription;

j. Respondent inappropriately prescribed methadone for opioid abuse disorder, while not accredited and certified to provide such maintenance;

k. Respondent failed to recognize Patient 4's tolerance to methadone for pain management, and/or failed to document the tolerance and the steps for dealing with the tolerance;

l. Respondent was prescribing methadone at a high dosage without medical indication or sufficient examination, and/or failed to document the medical indication or examination;

m. Respondent failed to conduct any EKG testing for arrhythmia, or other side effects of methadone therapy, and/or failed to document such testing;

n. Respondent failed to provide informed consent, and/or failed to maintain a record of informed consent.

## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G 76882, issued to Christopher Glennen Cooney, M.D.;

2. Revoking, suspending or denying approval of Christopher Glennen Cooney, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Christopher Glennen Cooney, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring;

4. Ordering Respondent Christopher Glennen Cooney, M.D., if placed on probation, to provide patient notification in accordance with Business and Professions Code section 2228.1; and

5. Taking such other and further action as deemed necessary and proper.

DATED: AUG 17 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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